Unum Short Term Disability

- Unum Short Term Disability insurance provides a benefit of up to 70% of your pre-disability weekly pay.
- There is a 30-day waiting period before the benefit begins, unless you are admitted to the hospital for 24 or more hours or have had outpatient surgery.
- You must not be working in any capacity to qualify for benefits!

How to apply for short term disability benefits
To file your claim, you will need to submit the following completed form(s)

Unum Claim for Disability Benefits Form – To be completed by all employees
This form has three sections to complete.

1. **Insured’s Statement:** Fill out this section first. Be sure to sign and date.
2. **Attending Physician’s Statement:** After you have completed the Insured’s Statement, your physician will need to enter your disability details in this section.
3. **Employer Statement:** Once the Insured Statement and Physician Statement are completed, return the form to Human Resources to complete section. We will submit the form to Unum for processing.

Hospital Form – To be completed by employees with a hospital stay of 24 hours or more or had outpatient surgery
In order to have the 30-day waiting period waived you will need to have the facility or physician complete the Hospital Form after your admission or procedure.

Return the completed form(s) to Human Resources by email, fax, or mail.

- Email: NAUHRBenefits@nau.edu Fax: (928) 523-7486
- Mail: PO Box 4113, Flagstaff, AZ 86011

How to report your time away from work
If your claim is approved, you will receive 70% of your pre-disability weekly pay from Unum. You are required to report at least 30% of your pay with sick, vacation or compensatory time (in that order). For example, if you work 80 hours per pay period you would report the following:

- 24 hours of sick time
- 56 Hours of leave without pay

If you have any questions about how to apply for Unum short term disability contact Human Resources at NAUHRBenefits@nau.edu or call (928) 523-2223.
Insured’s Statement

1. Insured’s full name ____________________________________________ Social Security No. _____________________________
   Street and No. _____________________________________________ City _____________________________ State _______ Zip Code _______
   Birthdate _____________________________ O Male O Female Telephone Number _____________________________
2. Date sickness began or injury occurred ______________________ Date last worked ______________________
3. Date of first treatment by a physician for present disability _____________________________
4. State nature of sickness or injury _____________________________
5. If injured, state how and where the injury occurred _____________________________
6. From and to what dates were you continuously totally disabled and prevented from performing any work? From _____________________________ To _____________________________
7. Date you were first able to do any work? _____________________________ Date last worked _____________________________
8. Has claim been filed or will claim be filed under any Worker’s Compensation Act or similar law? _____________________________

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, in Florida, a felony of the third degree.

I hereby authorize any hospital, physician, or surgeon to furnish the Provident Life and Accident Insurance Company any information desired.

Insured Signature _____________________________ Date _____________________________

Attending Physician’s Statement

Patient’s Name _____________________________________________ Age _____________________________
1. Nature of sickness or injury (Describe complications if any) _____________________________ ICD 9 CODE NO. _____________________________
2. Did this sickness or injury arise out of patient’s employment? O Yes O No
   If “yes”, explain _____________________________
3. Is disability due to pregnancy? O Yes O No
   Type of delivery O Cesarean O Vaginal
   What is the expected delivery date or actual delivery date? _____________________________
4. Nature of surgical or obstetrical procedure, if any, (describe fully) _____________________________ Date performed _____________________________
5. Give dates of treatment:
   Date of first office visit _____________________________ Date of last office visit: _____________________________
6. Hospital: Admission date _____________________________ time _____________________________ Discharge date _____________________________ time _____________________________
7. The patient has been continuously disabled (unable to work) from _____________________________ through _____________________________
8. Remarks: _____________________________

Date _____________________________ _____________________________
Street Address _____________________________________________ City or Town _____________________________ State _______ Zip Code _______
Attending Physician’s Signature _____________________________________________ Telephone Number _____________________________
SSN or Employers ID No. _____________________________________________

Employer’s Statement

1. Insured’s full name _____________________________________________ Birthdate _____________________________
   Social Security No. _____________________________ Occupation _____________________________
2. Date Employed _____________________________ Date insured _____________________________
3. Was Insured’s premium paid when disability began or loss occurred? O Yes O No
   To what date have premiums been paid? _____________________________
4. Has claim been filed or is it possible that claim will be filed under any Worker’s Compensation Act or similar law? O Yes O No
   Policy No. 498035 Claims Division 003 _____________________________
5. Date Insured last worked _____________________________ A.M. P.M.
   Date resumed work _____________________________ A.M. P.M.
6. Weekly Earnings _____________________________
   O Option A  O Option B  O Option C
   Remarks: _____________________________

Date _____________________________
Box 4, Flagstaff AZ 86011 – 4113

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries. 1163-04-ASU-003 (09/14)
Dear Claims Representative,

This letter is to confirm that the following employee who has submitted a claim for Short Term Disability Benefits was confined in-patient in a hospital for a minimum of 24 hours or had out-patient surgery.

Name: ____________________________  SSN: ____________________________

To be completed by the patient’s Health Care Provider after the procedure or discharge

Select the type of admission and provide the requested information

☐ Hospitalization  Date: ________ Time: _____ a.m. / p.m.  Date: ________ Time: _____ a.m. / p.m.

☐ Outpatient Surgery  Date: ________ Time: _____ a.m. / p.m.  Date: ________ Time: _____ a.m. / p.m.

☐ Birth of a Child  Date: ________ Time: _____ a.m. / p.m.  Date: ________ Time: _____ a.m. / p.m.

Baby’s Date and Time of Birth: __________________________________________

Type of Delivery:  ☐ Normal Delivery  ☐ C-Section

________________________________________  __________________________
Signature of Health Care Provider  Date

Thank you in advance for your prompt attention to this matter. If you have any questions, please contact Human Resources at (928) 523 - 2223 or nauhrbenefits@nau.edu